John Cutrone, LMHC, LLC
6810 Lyons Technology Circle, Suite 125, Coconut Creek, FL 33073
Phone: (561) 289-9722 Fax: (561) 544-7149 Website: www.CutroneLMHC.com

Adult Client Information Form

Name: Date of Birth: SSN#:

How do you Identify (Male, Female, Other - Describe):

Address (Street, City, State, Zip):

Home phone: Work phone: Cell Phone:

Is it OK to contact you on these #'s? ☐ No ☐ Yes If Yes, which one(s)?

Is it OK to email you?: ☐ No ☐ Yes If Yes, E-mail address:

Birthplace: Marital/Relationship status:

# of times married: # years in current marriage/partnership:

Occupation:

Employer:

Education (Level/Degree):

Spouse/Partner's name:

Their Occupation: Their Employer:

How many children do you have, if applicable?:

Name: Age: Currently living with you: ☐ No ☐ Yes

Name: Age: Currently living with you: ☐ No ☐ Yes

Name: Age: Currently living with you: ☐ No ☐ Yes

Name: Age: Currently living with you: ☐ No ☐ Yes

Emergency Contact

Name: Relation: Phone Number:

Address:

Who referred you:

Family doctor:

List any major health problems:

Please list any current medications/dosages:

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Have you been to therapy before?: ☐No ☐Yes

If yes, when (List Approx Dates)?:

Who did you see?:

For what reason(s)?:

Did it help (explain)?:

Please **Check** any of the following reasons for coming to see me:

	ADDICTIONS		COPING SKILLS		GAMBLING		NO INTERESTS		SEXUAL PROBLEMS
	AGORAPHOBIA		CUTTING		GENDER IDENTITY		PAINFUL THOUGHTS		SLEEP
	ALCOHOL USE		DEPRESSION		HEADACHES		PANIC ATTACKS		STOMACH TROUBLE
	ANGER		DIVORCE		HEALTH PROBLEMS		PARENTING		STRESS
	ANXIETY		DRUG USE/ABUSE		HOMICIDAL		PHOBIAS		SUBSTANCE USE
	APPETITE		EDUCATION		IMPOTENCE		RELATIONSHIPS		SUICIDAL IDEATION
	BREAK-UP		ENERGY		INSOMNIA		SADNESS		TIREDNESS
	CAREER		EXTREME FATIGUE		LEGAL MATTERS		SELF-CONTROL		TRAUMA
	CHILD ABUSE		FEARS		LONELINESS		SELF-ESTEEM		VIOLENCE
	COMPULSIONS		FETISHES		MAKING DECISIONS		SELF-HARM		WEIGHT
	CONCENTRATION		FINANCES		MARRIAGE		SEXUAL ABUSE		WORK
	CONFIDENCE		FRIENDS		NERVOUSNESS		SEXUALITY		Other:

Briefly describe Current/other reason(s) for seeking or therapy:

Please be aware that full payment is expected at the time of your visit. I generally operate on time so please be prompt for your appointment as it will end at the original scheduled time, unless discussed.

Since your appointment time is reserved **exclusively for you**, the cancellation policy is as follows: **Appointments must be canceled 24 hours in advance. Appointments which are not given a 24 hour notice and/or missed appointments without cancellation will be subject to the full fee, as if the appointment was kept. Thank you for your cooperation.**

Printed Name of Client Signature of Client Date